Your Child's Health History

Child's Name _____ Date _____

Parent's or Guardian's Name _____

Child's age:_____

If child is less than 2 years old, what was their birth weight?_____

Circle Yes or No

Has a doctor told you that your child has any medical conditions or problems? Yes No

If yes, what kinds? _____

Has a doctor told you that your child is allergic to one or more foods? Yes No

If yes, which foods? _____

Has a doctor told you that your child has lactose intolerance? Yes No

Does your child drink from a baby bottle? Yes No

Some children eat the following. Does your child? Yes No
If yes, which ones?"

- ☐ plaster
- ☐ paint chips
- ☐ dirt/clay
- ☐ newspaper
- ☐ ice (large quantities)
- ☐ other _____

Does your child have tooth decay or any problems with his teeth? Yes No

MUSTURS

PLEASE STOP HERE - THANK YOU